

Becket Systems

An Independent Review Organization
815-A Brazos St #499
Austin, TX 78701
Phone: (512) 553-0360
Fax: (207) 470-1075
Email: manager@becketystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/07/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 additional sessions of physical therapy to the left hip

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that medical necessity does not exist for 8 additional sessions of physical therapy to the left hip.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination
Plan of care dated
Progress note
CT chest
CT brain
Radiographic report
Designated doctor documentation
Employer's first report of injury or illness
Letter dated

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured when he was driving. He was rear-ended by another employee, causing him to black out and hit his head, cracking the window. CT scan of the brain shows no acute intracranial abnormalities. The patient was seen and diagnosed with knee strain, neck strain, trapezius strain and concussion with post-concussion syndrome headache. Note indicates that the patient has been back at work. Note indicates that the patient has not been working. Progress note indicates that the patient completed 14 visits of physical therapy. On physical examination strength is rated as +4/5 to 5/5 in the left lower extremity and -5/5 in the right lower extremity. Left hip range of motion is extension 11,

flexion 103, ER 18 and IR 16. Right hip range of motion is extension 13, flexion 110, ER 20 and IR 20 degrees. Initial request for 8 additional sessions of physical therapy was non-certified. He has completed at least 15 visits of physical therapy without significant improvement in his symptoms. He has exceeded the ODG recommendation of 9 visits for a sprain/strain of the hip. There are no physician notes provided with exam findings or a working diagnosis for his hip complaints. Additional therapy would not be recommended based on the information provided. The denial was upheld on appeal noting that the symptoms apparently are not getting worse or better. To summarize, there is increased strength but the symptoms are not getting better. No diagnostic examination results were reported. There is no evidence showing objective functional gain from previous sessions to warrant continuation of treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient has completed 15 sessions of physical therapy to date. The Official Disability Guidelines support up to 9 visits for the patient's diagnosis, and there is no clear rationale provided in the medical records to support the need to exceed this recommendation. There are no exceptional factors of delayed recovery documented. The patient's compliance with an active home exercise program is not documented. It is the opinion of the reviewer that medical necessity does not exist for 8 additional sessions of physical therapy to the left hip.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)